

DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE OF PARENTS: MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

REFERRING/CONSULTING PHYSICIAN \_\_\_\_\_

**PAST MEDICAL HISTORY**

Drug Allergies \_\_\_\_\_ Immunizations up to date? \_\_\_\_ yes \_\_\_\_ no

Current Medications \_\_\_\_\_ Previous Surgery \_\_\_\_\_

Medical Illnesses & Hospitalizations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chronic Conditions \_\_\_\_\_

Have you seen other medical specialists? \_\_\_\_ Pulmonary \_\_\_\_ Allergist \_\_\_\_ Cardiology \_\_\_\_ Gastroenterology

\_\_\_\_ Surgery \_\_\_\_ Other \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Length of pregnancy \_\_\_\_ Delivery: Vaginal \_\_\_\_ Caesarean \_\_\_\_ Breech \_\_\_\_ Breast Fed \_\_\_\_ Bottle Fed \_\_\_\_ How Long? \_\_\_\_

Birth Weight \_\_\_\_ Length of hospital stay at birth \_\_\_\_ Ventilator Use \_\_\_\_ Apnea Monitor \_\_\_\_

Problems during Neonatal period \_\_\_\_\_

Age at sitting \_\_\_\_ Age rolling over back to front \_\_\_\_ Age at speech \_\_\_\_ Age at walking \_\_\_\_

**SOCIAL HISTORY**

Patient lives with \_\_\_\_\_ Adopted \_\_\_\_ yes \_\_\_\_ no Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

Is the Child in Day Care? No \_\_\_\_ Yes \_\_\_\_ Current Grade in School \_\_\_\_ School Problems \_\_\_\_\_

Learning or Behavioral Issues \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY (Write Yes or No and Indicate Relationship)**

Diabetes \_\_\_\_\_ Kidney / Urinary Disease \_\_\_\_\_ Emotional Illness \_\_\_\_\_

Lung Disease / TB \_\_\_\_\_ Allergies / Asthma \_\_\_\_\_ Mental Retardation \_\_\_\_\_

Cancer \_\_\_\_\_ Blood Dyscrasias \_\_\_\_\_ Seizures / Epilepsy \_\_\_\_\_

Heart Disease / Stroke \_\_\_\_\_ Birth Defects \_\_\_\_\_ Substance Abuse \_\_\_\_\_

Hypertension \_\_\_\_\_ Cystic Fibrosis \_\_\_\_\_ Other \_\_\_\_\_

Thyroid Disorder \_\_\_\_\_



**MEDICAL INFORMATION (If circled yes, please also CIRCLE all conditions that apply)**

- Yes / No Unexplained weight gain or loss?
- Yes / No Recent fever? (above 100 degrees)
- Yes / No Eczema, itching, rashes, or large birth marks?
- Yes / No Eye surgery, glasses or contact lens?
- Yes / No Recurrent infection, congestion, or discharge in or from ears/nose/throat/mouth?
- Yes / No Heart murmurs, shortness of breath, high blood pressure?
- Yes / No Asthma, chest pain, recurrent cough?
- Yes / No Feeding problems, diarrhea, constipation, vomiting?
- Yes / No Kidney or bladder infection, pain with urination, inability to control urine?
- Yes / No Other joint pains, fractures? (other than what you are being seen for today)
- Yes / No Seizures, head trauma, delayed age for walking/talking, attention deficit disorders, learning issues at school?
- Yes / No Depression, behavioral problems, addiction?
- Yes / No Any known problems with thyroid, growth hormone, diabetes?
- Yes / No Bleeding problems, easy bruising, frequent nose bleeds, low blood count, sickle cell disease?
- Yes / No Recurrent unexplained arm or leg swelling, bumps or knots under the arm or in groin?
- Yes / No Environmental allergies, food allergies, sensitivity to costume jewelry or balloons?

**IF OVER AGE 12**

Do you use non prescription drugs? Yes / No  
 If yes, what kind? \_\_\_\_\_

**IF OVER AGE 14**

Do you drink alcohol? Yes / No  
 Do you use tobacco? Yes / No  
 (smoking or chewing)

**MENSTRUAL HISTORY(females over age 10)**

Have you started your periods? Yes / No  
 If you have started your periods, how long ago? \_\_\_\_\_  
 When was your last period? \_\_\_\_\_ reg \_\_\_\_\_ Irregular \_\_\_\_\_  
 Pain/Cramps \_\_\_\_\_ Days of Flow \_\_\_\_\_  
 Is there a possibility you are pregnant? Yes / No  
 Birth Control Method \_\_\_\_\_

**BARRIERS WHICH MAY IMPACT NURSING CARE / LEARNING:**

Do you have any <b>cultural concerns</b> that you would like to share with us? _____ No _____ Yes If yes, specify: _____	Is there an <b>inability to read or write</b> ? _____ No _____ Yes If yes, specify: _____
Do you have any <b>religious concerns</b> that you would like to share with us? (i.e. blood transfusions) _____ No _____ Yes If yes, specify: _____	Do you have any <b>emotional or psychological concerns</b> that you would like to share with us? _____ No _____ Yes If yes, specify: _____
Do you have a <b>language barrier</b> ? _____ No _____ Yes If yes, specify: _____	Do you have any <b>financial concerns</b> that you would like to share with us? _____ No _____ Yes If yes, specify: _____
Do you have any <b>physical, visual, hearing, speech or learning</b> impairments? _____ No _____ Yes If yes, specify: _____	<b>Other concerns</b> that you feel may affect the care of your child? _____ No _____ Yes If yes, specify: _____

Reviewed above Information:

\_\_\_\_\_  
 Physician Signature / Print Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 A.R.N.P. Signature / Print Name

\_\_\_\_\_  
 Date